STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155286	A. BUILDING 00 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON VILLAGE	200 KINGSTON CIR LIGONIER, IN 46767

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F0000	This visit was for Recertification and State Licensure Survey. Survey dates: August 6, 7, 8, 9, & 10, 2012 Facility number: 000184 Provider number: 155286 AIM number: 100267210 Survey team: Shelly Vice, RN-TC Honey Kuhn, RN Debora Kammeyer, RN Census bed type: SNF/NF: 48 Census Payor type: Medicare: 8 Medicaid: 29 Other: 11 Total: 48 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on August 16, 2012 by Bev Faulkner, RN	F0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies.This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.Requesting a desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on record reviews, observations and interviews, the facility failed to keep indwelling urinary catheter bag located within a dignity pouch. This affected 1 of 3 in a sample of 3 review for catheters. (Resident #33) Findings include: The clinical record of Resident #33 was reviewed on 8/10/12 at 9:00 a.m. The diagnoses for Resident #33 included but are not limited to: Advanced Huntington's chorea, dementia, expressive aphasia, sympathetic dysantonomia, chronic diarrhea, gastritis, neurogenic bladder, and depression. On 8/6/12 at 9:05 a.m., Resident #33 was observed in her room, lying in bed on her right side with a blanket over her head. The urinary Foley catheter was on the floor and was not in a dignity pouch. The urine was an amber color and there was a urine odor in the room. LPN #1 entered the	F0241	1. The catheter bag for resident #33 was immediately placed in a dignity pouch. 2. All other residents with a catheter were reviewed to ensure catheter bags were placed in a dignity pouch.3. Nursing staff was educated by the DNS on August 10, 2012 to keep catheter bags placed in a dignity pouch. The DNS/Designee will perform rounds daily on all shifts to ensure all catheters are placed in a dignity pouch. 4. The DNS or designee will monitor that all catheter bags are in a dignity pouch daily times 4 weeks, then weekly times 4 weeks, then monthly thereafter for at least 6 months. The results of the monitoring will be reviewed in CQI meeting. 5. Completion Date: 8/24/12	08/24/2012

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	room at 9:22 a.m., and called the resident by their name. The nurse explained to the resident that she had medications for the resident. The nurse assisted the resident to a sitting position and assisted her with swallowing her medications. The resident tried to communicate to the nurse. The nurse asked the resident if she wanted to lie back down to which she nodded her head yes. The nurse indicated the resident wanted to lay down. The resident repositioned herself onto her left side. The nurse positioned the catheter off of the floor. The catheter bag was not placed inside a dignity pouch. On 8/8/12 at 11:15 a.m., Resident #33 was observed in her recliner with her catheter bag in a pocket at the side of her recliner without a dignity pouch. There was no odor noted in room. On 8/10/12 at 8:05 a.m., Resident #33 was observed in her bed with her catheter bag in a blue dignity bag, with the tubing off of the floor. There were no urine odors noted at that time. On 8/10/12 at 9:05 A.M., LPN #2 was interviewed and indicated the catheter was to be in a blue dignity pouch.			

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	On 8/10/12 at 9:10 A.M., the care plan indicated the collection (Foley Catheter) bag was to be stored in protective dignity pouch. 3.1-3(t)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interviews, the facility failed to ensure safety inventions were in place to prevent a fall for 2 of 2 residents with a history of falls in a sample of 4 residents reviewed for falls. (Resident #5 and Resident #52) Finding includes: 1. The record of Resident #5 was reviewed on 08/08/12 at 1:30 p.m. Resident #5 was admitted to the facility on 01/25/12 with diagnoses including, but not limited to, (R) (Right) AKA (above knee amputation), post-op delirium, history of (L) (left) heel pressure ulcer, dementia, hypothyroidism, Alzheimer's dementia, edema, DJD (degenerative joint disease), intercranial hemorrhage, & CVA (cerebrovascular accident: stroke). Review of a MDS (Minimum Data Set: a tool used to assess a resident's needs and services), dated 02/20/12, indicated Resident #5 was severely	F0323	1. The careplan and CNA assignment sheet of resident #5 and resident # 52 were both reviewed to ensure all safety interventions are in place to prevent a fall. 2. All other residents had the potential to be affected. All fall careplans and CNA assignment sheets have been reviewed to ensure all fall interventions are in place. 3. The nursing staff has been educated on American Sr. Communities Fall Management Program by the DNS on 8\10\12. The DNS/Designee will perform rounds daily on all shifts to ensure all fall interventions are in place. A root cause analysis will be conducted on each fall to ensure appropriate interventions are in place. 4. The DNS or designee will review all falls and fall interventions to ensure compliance with American Sr. Communities Policy. The DNS or designee will monitor weekly times 4 weeks that all fall interventions are in place, then monthly thereafter for at least 6 months. The results of the monitoring will be reviewed by the CQI committee.5. Completion Date: 8/24/12	08/24/2012

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	cognitively impaired and never/rarely made decisions. The MDS indicated Resident #5 did not ambulate and was unable to maintain balance from a seated position to a standing position or to transfer from surface to surface (between bed and chair) without total assistance. The MDS also indicated the resident had limited ROM (Range of Motion) of all extremities. Review of nurses notes indicated,: "02/23/12 9 p (p.m.), Resident up in W/C (wheelchair) for supper. Ate poorly, refused to have help c (with) supper meal. T&P (Turned and Positioned) q (every) 2* (hours) while in bed..." "02/24/12 12 a.m.: CNA (Certified Nurse Assistant) summoned nurse, and writer during bed check. Resident observed on mat beside her low bed, parallel to bed set in lowest position. Resident had small blanchable red mark found in between eye brows. No other injury found during assessment...." There was no indication Resident #5 was assessed between the two entries Review of a "FALL CIRCUMSTANCE REPORT," dated 02/24/12, indicated			

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	the fall was unwitnessed. "2. Describe what the resident was doing prior to the fall (interview resident, staff, visitors) if able: 'Resident did not respond. Resident was in bed before fall.' " "3. Describe the position of the resident when first observed after fall...: 'Resident was lying parallel to bed on bed mat. Resident was face down with arms crossed in front of her.' " "4. Describe resident appearance at time of fall...: 'Resident was in gown lying face down on mat with arms crossed.' ..." Review of a "Fall Care Plan," dated 02/07/12, indicated: "Fall risk related to: History of falls, balance difficulty with transitions, Antidepressant/Antipsychotic medication use, Right AKA, ROM (range of motion) impairment, visual impairment, Dementia with Psychosis. Goal: Resident will have no significant injury relate to falls. Approach: Low bed with mat to the floor, no siderails.... Encourage and remind resident to use call light... Assess resident frequently...." Review of the "POST FALL			

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	INVESTIGATION" indicated: "Has resident fell in last 30 days? 'yes'.... What was the resident doing or attempting to do at the time of the fall? 'Res (resident) in bed found on mat'..." "What intervention(s) was put in to place to prevent another fall? 'Assess resident frequently. Make sure bed is in the lowest position. Make sure mat is parallel to bed to reduce injuries'." Review of the documentation indicated the facility had not thoroughly investigated to determine how the totally dependent resident fell from the bed. . The ADNS (Assistant Director Nursing Services) was interviewed on 08/09/12 at 3:00 p.m. The ADNS indicated Resident #5 was totally dependent and had a history of being combative, at times, with care. The DNS (Director Nursing Services) was interviewed on 08/10/12 at 8:30 a.m. The DNS indicated Resident #5 was in a regular bed set in the lowest position with a mat placed next to the bed. 2. The record of Resident #52 was reviewed on 08/08/12 at 9:00 a.m.			

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	Resident #52 was admitted to the facility on 06/18/12 with diagnoses including, but not limited to, diabetes, atrial fibrillation (irregular heartbeat), extreme morbid obesity, chronic lumbar back pain, HTN (hypertension: high blood pressure), sleep apnea, CVA (cerebrovascular accident: stroke), COPD (chronic obstructive pulmonary disease), peripheral neuropathy, gout, depression, hyperlipidemia, proteinuria (protein in urine), and anxiety. The resident had a history of falls prior to admission to the facility. Review of a fall, which occurred on 06/26/12 at 8:45 p.m., indicated the resident being assisted from his W/C (wheelchair) to the shower chair with a gait belt (a belt applied to resident's to promote safety by staff during transfers) by a CNA (Certified Nurses Assistant). Resident #52's knee buckled and the resident "sat down c (with) the help of CNA." Review of a MDS (Minimum Data Set: a tool to assist in assessment needs of residents), dated 06/25/12, indicated Resident #52 required maximum assist or minimum of 2 people for transfers from bed, chair, and for toileting.			

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	Review of care plans indicated an admission care plan which indicated the resident required a Hoyer lift (a hydraulic apparatus to assist staff in transfers) for transfers. Review of the initial care plan indicated: "06/29/12:...ADL (Activities Daily Living)/Rehabilitation Potential: Resident needs assistance with ADL's related to: Balance difficulty during transitions, Morbid Obesity, LE (left effect) CVA, Chronic low back pain, Neuropathy, COPD...May be transferred via (by way of) Hoyer lift." The DNS (Director Nursing Services) was interviewed on 08/09/12 at 9:48 a.m. The DNS indicated the internal investigation found the resident refused to allow staff to utilize the Hoyer lift for the transfer. The DNS also indicated the CNA did not attempt to get assistance from other staff. Review of the facility's "Fall Management Program: 06/2012" policy & procedure, provided by the DNS on 08/10/12 at 8:30 a.m., indicated: "POLICY: It is the policy of American Senior Communities to ensure residents residing within the facility will maintain maximum physical			

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	functioning through the establishment of physical, environmental, and psychosocial guidelines to prevent injury related to falls." "PROCEDURE: Fall risk:... 2. All new admissions will be considered at fall risk based upon his/her new living arrangements, and his/her reasons for being admitted in to (sic) the nursing facility." 3.1-45(a)(2)			